

TO HOSPITAL/ATOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12675

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12635

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Still Pond</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural X Still Pond</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>7</u>	
3. NAME OF DECEASED (Type or print) <u>JANIE</u> First <u>Rebecca</u> Middle <u>Bramble</u> Last		4. DATE OF DEATH <u>November 14</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 1 1884</u> 9. AGE (In years last birthday) <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>George R. Haddaway</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Hericks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Charles W. Jones, Betterton, Md</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage</u> DUE TO <u>Cerebral hemorrhage</u> (c) <u>Cerebral hemorrhage</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>10 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-2</u> 19 <u>60</u> to <u>11-14</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11-11</u> 19 <u>60</u> and that death occurred at <u>10:17</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>A.C. Dick</u>		22b. DATE SIGNED <u>11-14-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		22d. ADDRESS <u>Chestertown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/17/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 16 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12662

12637

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 1 hr.-15 Min.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				f. STREET ADDRESS 1 Main st.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marion Middle E. Last Chandler				4. DATE OF DEATH Month 11 Day 20 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/16/21	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months 11 Days 20 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fishery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Chandler				14. MOTHER'S MAIDEN NAME Henrietta Vorbringer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. W. W. 11 212-16-7951		17. INFORMANT Address (Wife) Lillian Chandler, Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420 IMMEDIATE CAUSE (a) Myocardial Infarct Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 420 DUE TO (c) 420 DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/20/60 to 11/20/60 , that (I) (we) last saw the deceased alive on 11/20/60 , and that death occurred on 11/20/60 at 9:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Wm. M. Gatewood		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/21/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-23-60		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town, or county) (State) Rock Hall Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams - Chestertown		ADDRESS		25a. REC'D BY REGISTRAR NOV 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kneib	

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“I don’t do it.”

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12663
CERTIFICATE OF DEATH

12638

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. STREET ADDRESS 416 High Street			
3. NAME OF DECEASED (Type or print) First Eleanor Middle Elenora Last Isabel Cook				4. DATE OF DEATH Month 11 Day 10 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/17/85	
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Stephen B. Hickman				14. MOTHER'S MAIDEN NAME Mary R. Jewell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Harry Cook, 416 High St., Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post-operative State: Gall-stone-ileus INTERVAL BETWEEN ONSET AND DEATH 12 hrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-8-1960 to 11-10-1960 , that (I) (we) last saw the deceased alive on 11-9-1960 , and that death occurred at 12:15 AM , from the causes and on the date stated above.							
22a. SIGNATURE A.T. KEEFE, M.D.				22b. DATE SIGNED 11-10-60		22c. PHYSICIAN'S NAME (Type) A.T. KEEFE, M.D.	
22d. ADDRESS CHESTERTOWN, Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/13/1960		23c. NAME OF CEMETERY OR CREMATORY Chester Cem.		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				25a. REC'D BY REGISTRAR NOV 14 '60		25b. REGISTRAR'S SIGNATURE Clara S. Evans	

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Level 1

Henry Cook, 424 High St., Boston, Mass.

revised 11-2-2008

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN 1b 2 WEEKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle LEONARD Last DEATON		4. DATE OF DEATH Month NOVEMBER Day 14 Year 1960	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 FEB. 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 75 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILLIP H DEATON		14. MOTHER'S MAIDEN NAME MARTHA BLAKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217013537	
17. INFORMANT MRS. A. DEATON - CENTREVILLE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERIOSCLEROSIS & THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 5 ± YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MICROACINAR CARCINOMA OF PROSTATE; URINARY TRACT INFECTION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCTOBER 1959 to 14 NOV. 1960 , that (I) (see) last saw the deceased alive on 14 NOV. 1960 , and that death occurred at 11:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE J. Kent Young		22b. DATE SIGNED 11/15/60	
22c. PHYSICIAN'S NAME (Type) J. KENT YOUNG		22d. ADDRESS 105 Chesterfield Ave. Centreville Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/17/60	
23c. NAME OF CEMETERY OR CREMATORY BORRISVILLE		23d. LOCATION (City, town, or county) (State) Centreville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		25a. REC'D BY REGISTRAR NOV 28 '60	
ADDRESS C. Hank Hill Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kneaf	



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Elias Last Elias				4. DATE OF DEATH Month Nov. Day 16 Year 1960			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/28/1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 3		IF UNDER 24 HRS. Hours 1 Min. 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George J. Elias				14. MOTHER'S MAIDEN NAME x Ida May Hynson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-12-3528		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 23 IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 11 days Years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-8-1960 to 11-16-1960 , that (I) (we) last saw the deceased alive on 11-16-1960 , and that death occurred at 1115p from the causes and on the date stated above.							
22a. SIGNATURE A. C. Dick				22b. DATE SIGNED 11-17-60			
22c. PHYSICIAN'S NAME (Type) A. C. Dick				22d. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/19/60		23c. NAME OF CEMETERY OR CREMATORY Pomona Cem. near - Chestertown, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Jenneth W. W. W.				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE NOV 21 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEMORANDUM FOR THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum format with a subject line and several paragraphs of text.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and if any event within 72 hours after death.

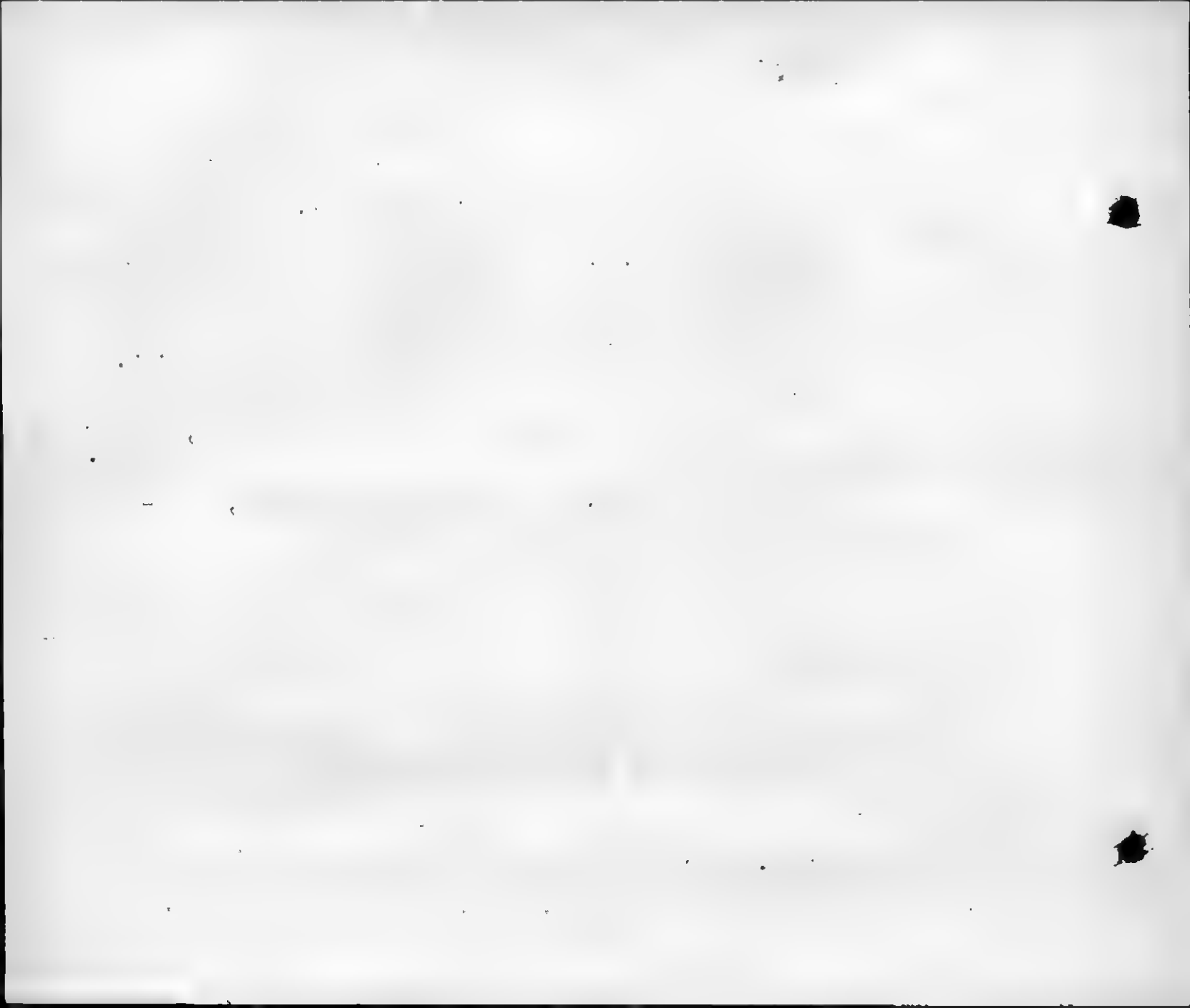
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15M 9/59

12666

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12641

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 26 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown (Lifetime)		d. STREET ADDRESS 117 Railroad Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eylett Middle M. R. Last Gland		4. DATE OF DEATH Month November Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1896
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own & private homes Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Robinson		14. MOTHER'S MAIDEN NAME Harriett Berry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-07-6524	
17. INFORMANT Hospital records & patient, Chestertown Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis (Primary site unknown, but probably Abdominal) DUE TO (b) 5-6 months INTERVAL BETWEEN ONSET AND DEATH DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/30 to 11/24 , 1960 , that (I) (we) last saw the deceased alive on 11/24 1960 , and that death occurred at 12 noon in the causes and on the date stated above.			
22a. SIGNATURE Robert W. Farr		22b. DATE SIGNED 11/25/60	
22c. PHYSICIAN'S NAME (Type) Robert W. Farr		22d. ADDRESS Chestertown, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/60	
23c. NAME OF CEMETERY OR CREMATORY Janes (col.) Cem.		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Samuel W. W. W.		25a. REC'D BY REGISTRAR DATE NOV 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			



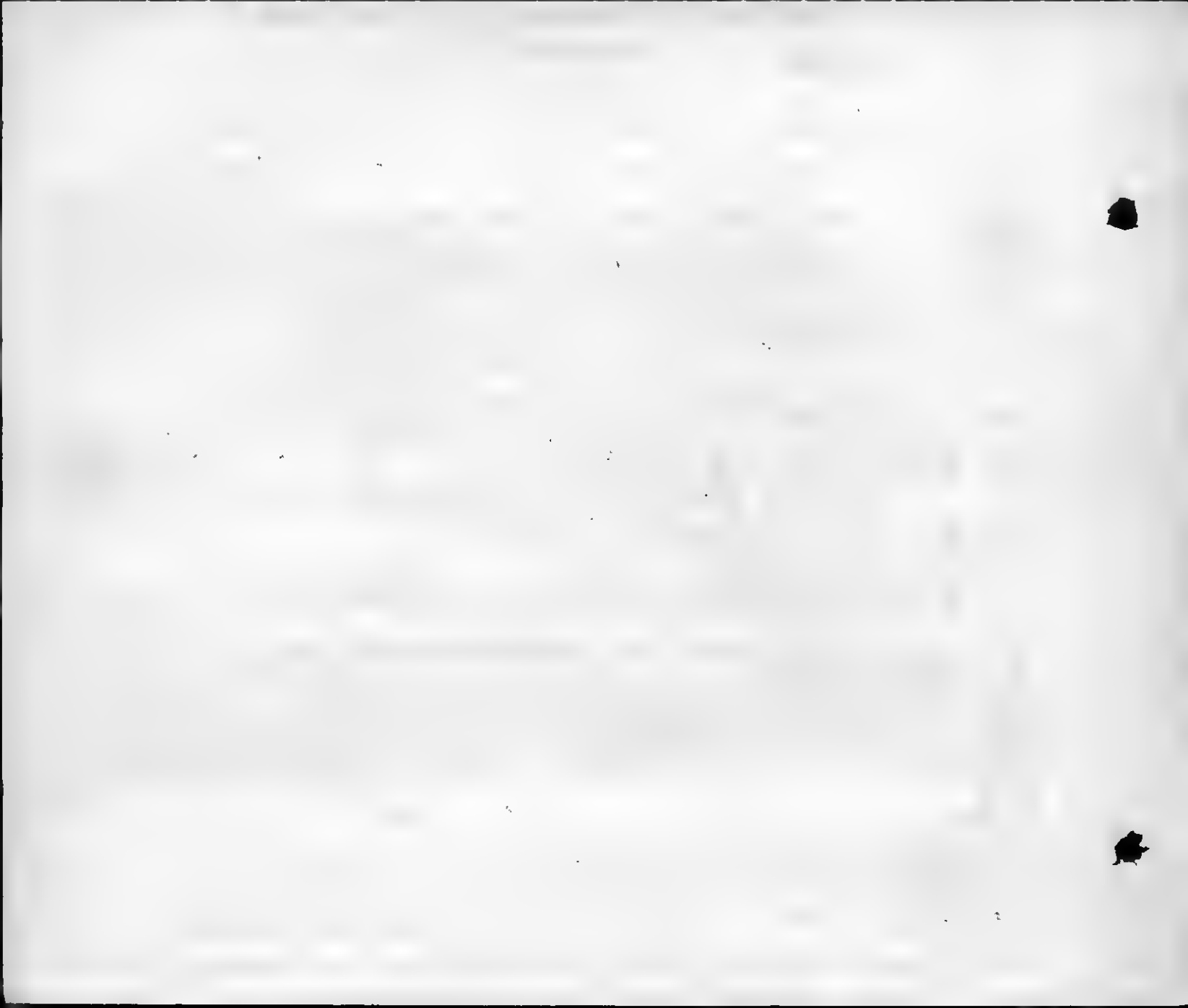
12676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) NANCY First CAROLE Middle HEINEFIELD Last		4. DATE OF DEATH Month Nov. Day 22 Year 1960	
5. SEX Fem	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 8 - 1944
9. AGE (In years last birthday) 16 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES HEINEFIELD		14. MOTHER'S MAIDEN NAME LORRAINE GLENN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT CHARLES HEINEFIELD		Address ROCK HALL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 18, 1955 to Nov. 22, 1960 , that I last saw the deceased alive on Nov. 22, 1960 , and that death occurred at 6:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert C. Vitsch		M.D. Rock Hall	
PHYSICIAN'S NAME (Type) ROBERT C. VITSCH - MD. ROCK HALL, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	Nov. 25	Wesley Chapel	Rock Hall MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR NOV 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12643

12677

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tolchester Estates</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tolchester</u>		e. STREET ADDRESS <u>1 Tolchester</u>	
3. NAME OF DECEASED (Type or print) <u>Lella</u> First <u>J</u> Middle <u>Hubbard</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9 1884</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles H. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Reed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-0222</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>146X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Nasopharynx</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> to <u>Nov</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct</u> , 19 <u>60</u> , and that death occurred at <u>Rock Hall</u> , from the cause and on the date stated above.			
DEATH SIGNATURE <u>Willis M. Lawrence</u> M.D.		DATE SIGNED <u>11/10/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 11/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Hall Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lillian V. Williams</u> ADDRESS <u>Chesapeake Ind.</u>		24a. REC'D BY REGISTRAR <u>NOV 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Haines</u>

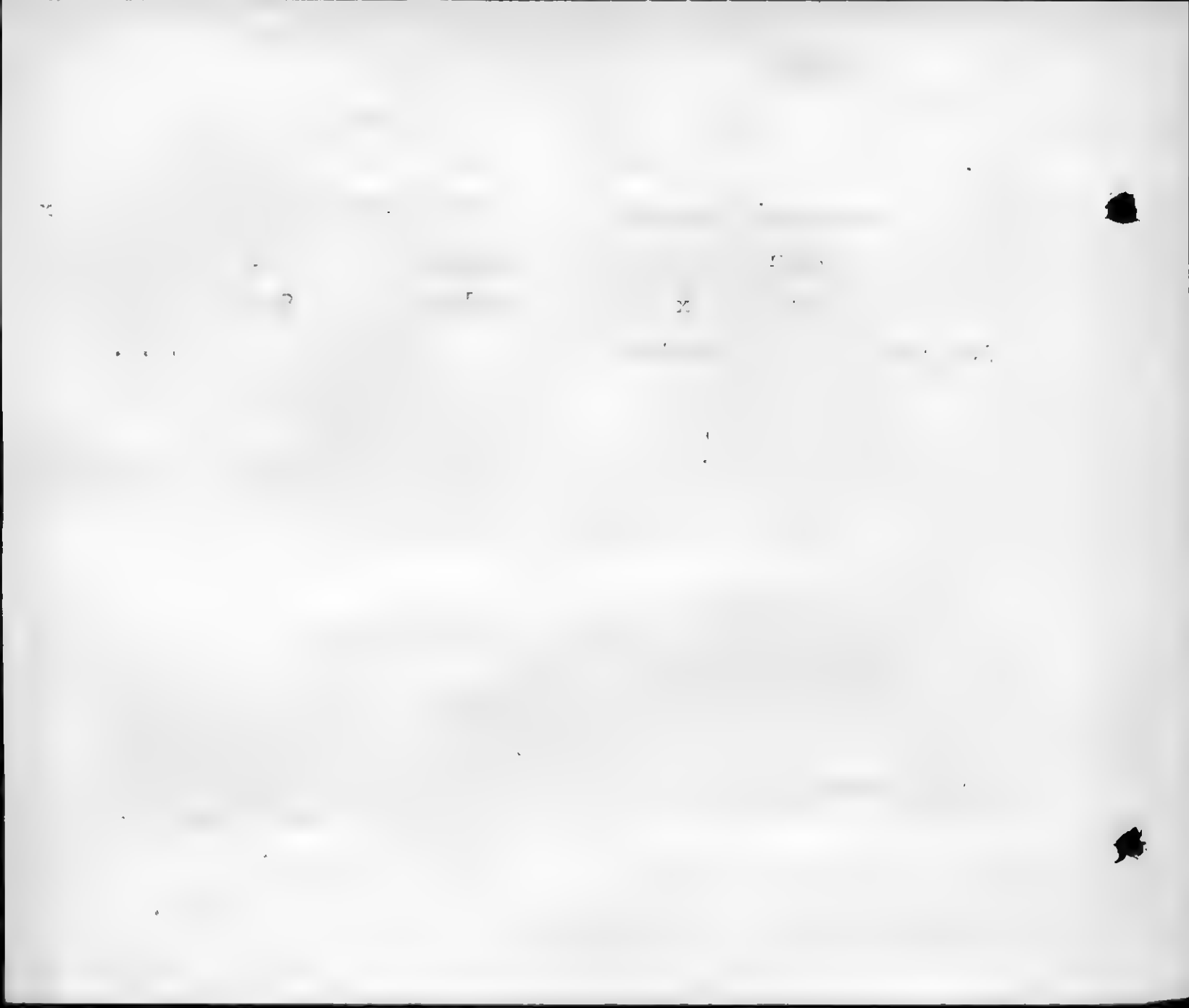


12667

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12644

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS Front Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Johnson Last Johnson		4. DATE OF DEATH Month 11 Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/80 9. AGE (In years last birthday) 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY Fishing	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles T. Johnson 14. MOTHER'S MAIDEN NAME Mary E. Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Don't know		16. SOCIAL SECURITY NO. Don't Know 17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 420.0 DUE TO Condit ans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/10/60 to 11/14/60 , 19____, that (I) (we) lost the deceased alive on 11/14/60 and that death occurred at 8:37 M, from the causes and on the date stated above.			
22a. SIGNATURE William M. Gatewood 22c. PHYSICIAN'S NAME (Type) William M. Gatewood		22b. DATE 11/15/60 22d. ADDRESS Chestertown, Md. M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 11/17/60	23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	23d. LOCATION (City, town, or county) (State) Chestertown, Md.
24. FUNERAL DIRECTOR'S SIGNATURE William Wells ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR NOV 18 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



12668

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12645

1 PLACE OF DEATH a. COUNTY Kent MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c LENGTH OF STAY IN 1b 5 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		d STREET ADDRESS 17X-2	
3 NAME OF DECEASED (Type or print) First John Middle Wesley Last Jones		4 DATE OF DEATH Nov. 5, 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/00
9 AGE (In years last birthday) 60		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11 BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME John Jones	
14. MOTHER'S MAIDEN NAME Susie Williams		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO 220-12-2346		17. INFORMANT John Wesley Jones	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 10-31 , 1960 , to 11-5 , 19 60 , that (I) (we) last saw the deceased alive on 11-5 , 19 60 , and that death occurred at 8p. M, from the causes and on the date stated above			
22a. SIGNATURE <i>A.C. Dick</i>		22b. DATE SIGNED 11-8-60	
22c. PHYSICIAN'S NAME (Type) A.C. Dick, M.D.		22d. ADDRESS Chestertown, Maryland.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/9/60	
23c NAME OF CEMETERY OR CREMATORY Pondtown Cemetery		23d LOCATION (City, town, or county) (State) near Crumpton, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Fennell Waley</i>		25a REC'D BY REGISTRAR NOV 14 '60	
ADDRESS Chestertown, Md.		25b REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director may be used by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12669

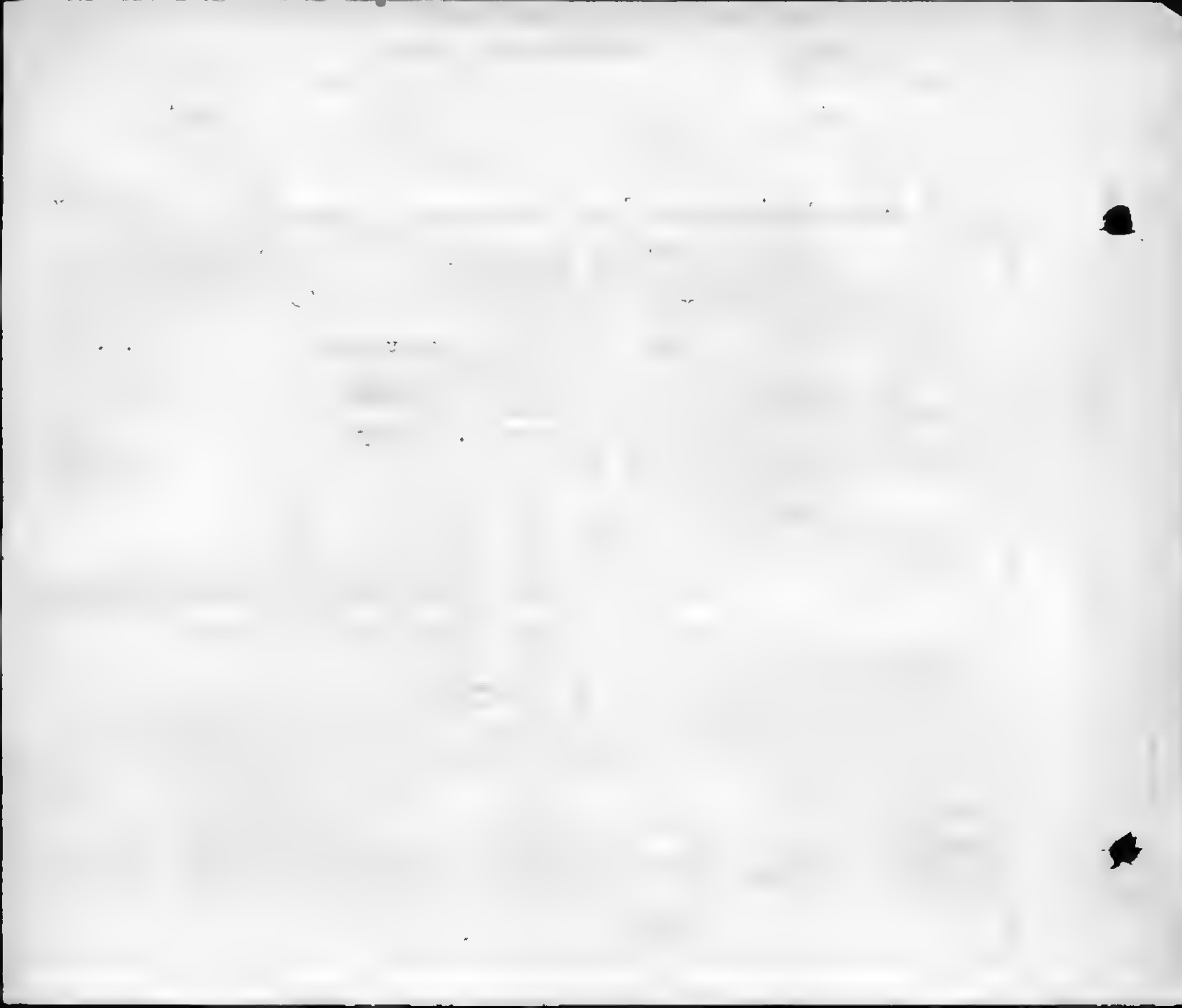
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 39 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lita Hartman Kelsey		4. DATE OF DEATH Month Day Year Nov. 9, 1960 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/86
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Hartman	
14. MOTHER'S MAIDEN NAME Alice Alizes		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Don't know		17. INFORMANT Lita H. Kelsey Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gravely ill leukemia chronic 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured right hip surgically repaired			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-31-1960 to 11-9-1960 , that I last saw the deceased alive on 11-9-60 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Paul Ross M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 203 N. Queen St 11-9-60	
PHYSICIAN'S NAME (Type) HARRY PAUL ROSS		Chestertown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE OF BURIAL Nov. 11, 1960	22c. NAME OF CEMETERY OR CREMATORY Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE NOV 14 '60	24b. REGISTRAR'S SIGNATURE L. H. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



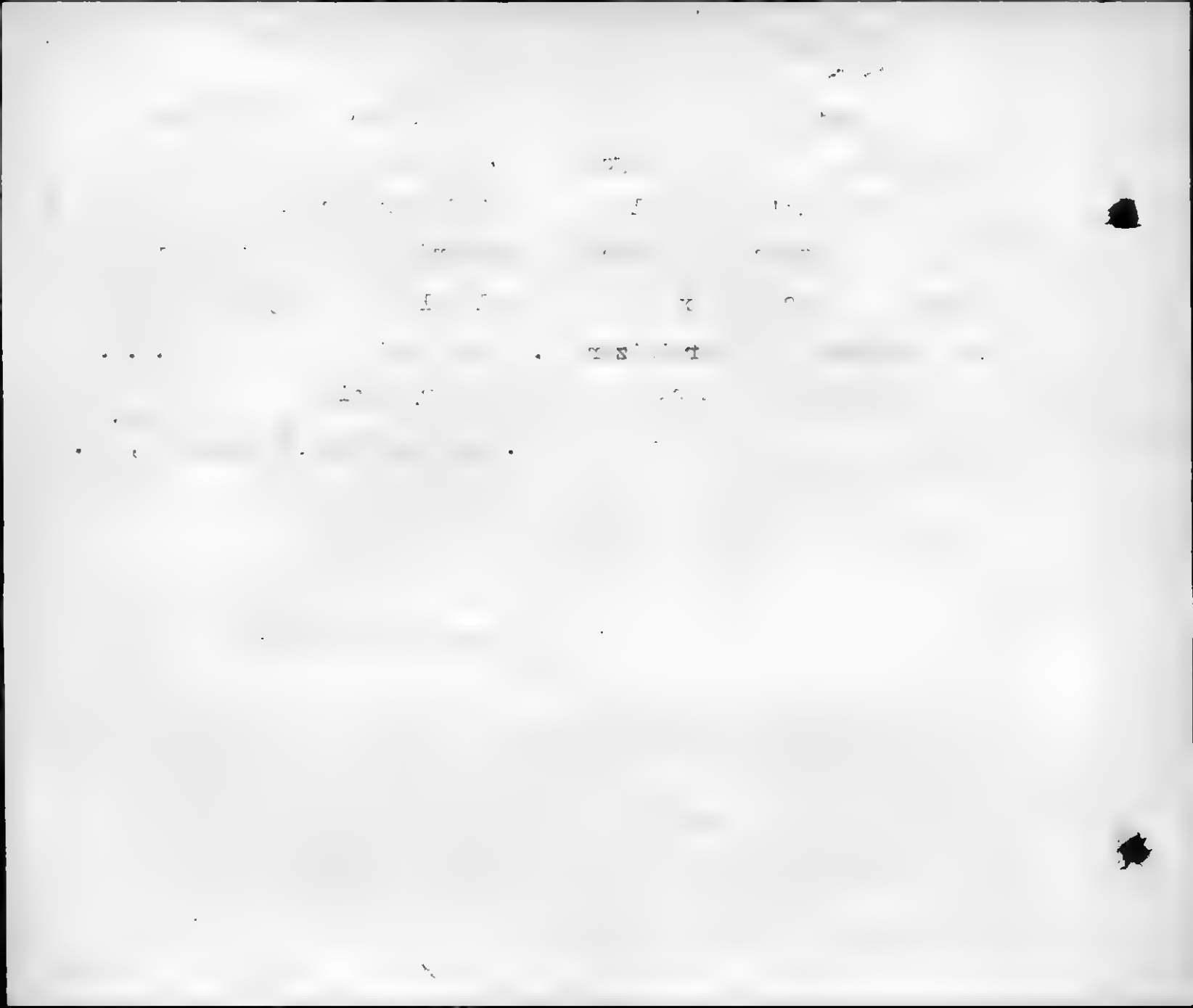
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12670

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12647

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN lb 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Joseph Last Leonard				4. DATE DEATH Month 11 Day 10 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/11/91	
9. AGE (In years last birthday) 69 yrs		10. UNDER 1 YEAR Months 11 Days 10 Hours 19 Min 60		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Manager				10b. KIND OF BUSINESS OR INDUSTRY Fertilizer Co.			
13. FATHER'S NAME Thomas Ellsworth Leonard				14. MOTHER'S MAIDEN NAME Mary Theiss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-05-7254			
17. INFORMANT Mrs. Etta May Reed				18. ADDRESS 518 Cannon Street, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral artery disease DUE TO (b) Arteriosclerosis, generalized DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema, polyposis coli, diverticulitis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-27 1960 to 11-10 1960 , that (I) (we) last saw the deceased alive on 11-9 1960 , and that death occurred at 4:30 M, from the causes and on the date stated above							
22a. SIGNATURE A.C. Dick M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE 11-10-60							
22c. PHYSICIAN'S NAME (Type) A.C. Dick ADDRESS Chestertown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/13/60		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Wells				25a. REC'D BY REGISTRAR DATE NOV 14 '60			
				25b. REGISTRAR'S SIGNATURE Arthur L. Wells			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

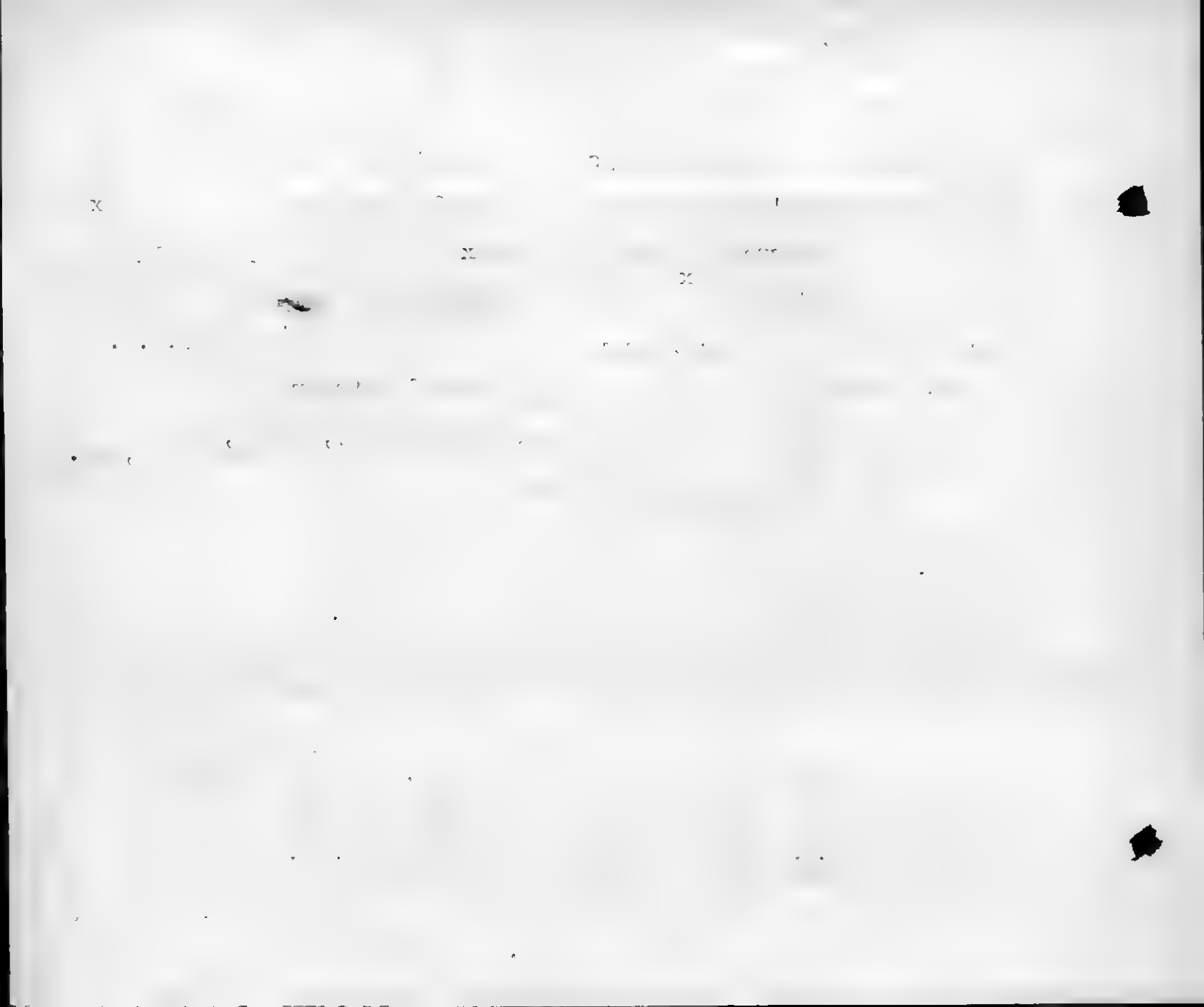
12671

12648

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 31 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George (none) Lomax				4. DATE OF DEATH Month Day Year 11 11 19 60			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895 May 1 / 1895	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lomax				14. MOTHER'S MAIDEN NAME Isabel Butcher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-20-0003		17. INFORMANT Address Emma Lomax, (wife), RFD#2, Box 110 Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Cerebral hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 weeks ??							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic sepsis due to infected decubitus ulcers, anaemia.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 10-10-60 to 11-11-60 , 19 60 , that (I) (we) last saw the deceased alive on 10-10-60 , 19 60 , and that death occurred on 11-11-60 , 19 60 , at 9a A.M., from the causes and on the date stated above.							
22a. SIGNATURE A.C. Dick		22b. PHYSICIAN'S NAME (Type) A.C. Dick		22c. ADDRESS Chestertown, Md.		22d. DATE SIGNED 11-11-60	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 11/15/60	23c. NAME OF CEMETERY OR CREMATORY Sandy Bottom Cem.		23d. LOCATION (City, town, or county) (State) near - Chestertown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Ed Smith		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE NOV 16 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kiser		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal of the body in any event within 72 hours after death.

12672
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12643

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 11 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eugene Middle Thornton Last Thornton		4. DATE OF DEATH Month 11 Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/85
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 18 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Manager		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Norwood T. Thornton		14. MOTHER'S MAIDEN NAME Tabitha Jane Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 222-20-2070	
17. INFORMANT Eugene Thornton -Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema			INTERVAL BETWEEN ONSET AND DEATH 2 hrs
(b) Myocardial infarction			2 days
(c) Generalized arteriosclerosis			years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gross hematuris (probably bladder carcinoma)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-18 19 60 to 11-18 19 60 that (I) (we) last saw the deceased alive on 11-18 19 60 and that death occurred at 10:20 pm from the causes and on the date stated above.			
22a. SIGNATURE HARRY PAUL ROSS, M.D.		22b. DATE 11-19-60	
22c. PHYSICIAN'S NAME (Type) HARRY PAUL ROSS, M.D.		22d. ADDRESS 203 N. Queen St., Chestertown, Md	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 11-22-60	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	23d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.
24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR NOV 28 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

(M)

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne Hospital (1 day)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lucille F. Turner		4. DATE OF DEATH Month Day Year Nov. 9, 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/19/1907
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Foulks		14. MOTHER'S MAIDEN NAME Mary Foley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-24-2366	
17. INFORMANT Robert Turner		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock due to injuries sustained in auto accident 11/8/60 DUE TO Fractured ribs - rt with hemothorax, Ruptured spleen Conditions, if any, which gave rise to immediate cause (b) Was in a car - locomotive grade crossing collision. (c) In shock on arrival hospital, Splenectomy 300 ccblood PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) rt thorax. Never aroused from shock.		INTERVAL BETWEEN ONSET AND DEATH 15 hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) see above Auto collision with train.	
20c. TIME OF INJURY Month, Day, Year 5:30 p.m. 11/8 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) grade crossing		20f. (City or town) (County) (State) Ridgely, Caroline Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R. Farr</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1960	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		24a. REC'D BY REGISTRAR NOV 14 '60	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE <i>J. Willis Wells</i>	

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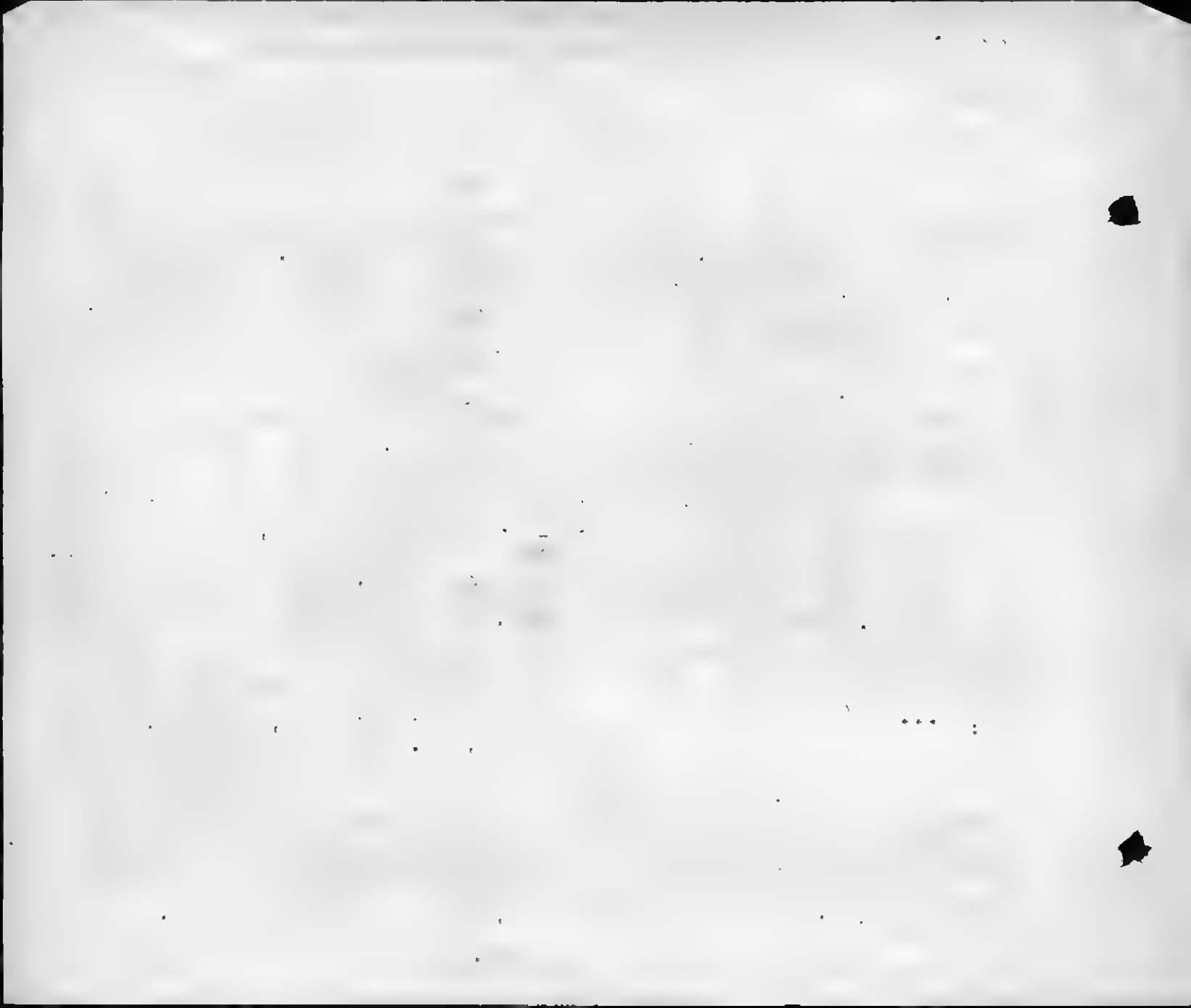
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 5 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

12678 12651
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Worton c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) near Coleman's Corner RD Worton		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 1542 N. Payson St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cramer Bennie Vaughn		4. DATE OF DEATH Month Nov. Day 16, Year 1960	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1912
9. AGE (In years last birthday) 48		10. IF UNDER 1 YEAR Months 4 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Company	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter Vaughn	
14. MOTHER'S MAIDEN NAME Roxanna Vinson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 215-09-5513		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple shot gun pellet injuries involving rt. chest & anterior chest (80 to 100) DUE TO (b) a few min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Shot accidentally while hunting			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot accidentally while hunting		20c. TIME OF INJURY Month, Day, Year 11/16/60 Hour 2:30 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
20f. (City or town) Worton		(County) Kent	
(State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Robert W. Farr		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/17/60	
Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 11/21/60		22c. NAME OF CEMETERY OR CREMATORY Carver Mem. Ch. Laurel	
22d. LOCATION (City, town, or country) Md.		23. FUNERAL DIRECTOR William A. Phillips	
ADDRESS 1808 N. Marshall		24a. REC'D BY REGISTRAR NOV 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

June 1915

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may be reviewed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12674

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12652

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Angie Middle Lina Last Wilmer				4. DATE OF DEATH Month 11 Day 21 Year 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/16/86	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 11 Days 21 Hours 19 Min.		11. IF UNDER 24 HRS. Months 11 Days 21 Hours 19 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Alexander Piner				14. MOTHER'S MAIDEN NAME Katherine Banner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT (Husband) John H. Wilmer, Still Pond, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Broncho Pneumonia IMMEDIATE CAUSE (a) several days 491X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 11/20 60 11/21 60			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Still Pond (County) Still Pond (State) Md.				21. I certify that (I) (this hospital) attended the deceased from 11/21 60 to 11/21 60 , that (I) (we) last saw the deceased alive on 11/21 60 , and that death occurred at 11/21 60 M, from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Farr				22b. DATE SIGNED 11/22/60			
22c. PHYSICIAN'S NAME (Type) Robert W. Farr				22d. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/26/60			
23c. NAME OF CEMETERY OR CREMATORY Still Pond (Colored)				23d. LOCATION (City, town, or county) (State) Still Pond. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Harris				25a. REC'D BY REGISTRAR NOV 28 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. Harris				25c. DATE			

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